

Laboratory-identified MDRO or CDI Event

Instructions for this form are available at: http://www.cdc.gov/nhsn/forms/instr/57_128.pdf

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*required for saving

Facility ID:		Event #:	
*Patient ID:		Social Security #:	
Secondary ID:		Medicare #:	
Patient Name, Last:		First:	Middle:
*Gender: M F		*Date of Birth:	
Ethnicity (Specify):		Race (Specify):	
Event Details			
*Event Type: LabID		*Date Specimen Collected:	
*Specific Organism Type: (Check one)			
<input type="checkbox"/> MRSA <input type="checkbox"/> MSSA <input type="checkbox"/> VRE <input type="checkbox"/> <i>C. difficile</i> <input type="checkbox"/> CephR-Klebsiella <input type="checkbox"/> CRE- <i>E. coli</i> <input type="checkbox"/> CRE- <i>Enterobacter</i> <input type="checkbox"/> CRE-Klebsiella <input type="checkbox"/> MDR-Acinetobacter			
*Outpatient: Yes No		*Specimen Body Site/System: *Specimen Source:	
*Date Admitted to Facility: _____		*Location: _____	*Date Admitted to Location: _____
Last physical overnight location of patient immediately prior to arriving into facility (applies to specimen(s) collected in outpatient setting or <4 days after inpatient admission) (Check one):			
<input type="checkbox"/> Nursing Home/Skilled Nursing Facility <input type="checkbox"/> Personal residence/Residential care <input type="checkbox"/> Other Inpatient Healthcare Setting (i.e., acute care hospital, IRF, LTAC, etc.) <input type="checkbox"/> Unknown			
*Has patient been discharged from <u>your</u> facility in the past 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, date of last discharge from your facility: _____			
Has patient been discharged from <u>another</u> facility in the past 4 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If Yes, from where (Check all that apply):			
<input type="checkbox"/> Nursing Home/Skilled Nursing Facility <input type="checkbox"/> Other Inpatient Healthcare Setting (i.e., acute care hospital, IRF, LTAC, etc.)			
Custom Fields			
Label		Label	
_____ / ____ / ____		_____ / ____ / ____	
_____		_____	
_____		_____	
_____		_____	
Comments			
<p>Assurance of Confidentiality: The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).</p> <p>Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0666).</p>			